No. 98-889

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In the Supreme Court of the United States
October Term, 1998

WASHINGTON PHYSICIANS SERVICE ASSOCIATION; PACIFICARE OF WASHINGTON, INC., a health care service contractor; SELECTCARE HEALTH PLANS, a Health Maintenance Organization; QUALMED WASHINGTON HEALTH PLAN, INC., a Health Maintenance Organization; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, INC., a Health Maintenance Organization; BLUECROSS AND BLUE-SHIELD OF OREGON, a health care service contractor; GROUP HEALTH COOPERATIVE OF PUGET SOUND, a Health Maintenance Organization; PERMERA BLUE CROSS (formerly BLUE CROSS OF WASHINGTON AND ALASKA, and MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON), a health care service contractor; REGENCE BLUESHIELD (formerly PIERCE COUNTY MEDICAL BUREAU, INC., and KING COUNTY MEDICAL BLUESHIELD), a health care service contractor,

Petitioners,

v.

CHRISTINE GREGOIRE, in her official capacity as Attorney General for the State of Washington; DEBORAH SENN, in her official capacity as Insurance Commissioner of the State of Washington,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

Whether the court of appeals correctly held that a Washington state statute that requires policies of health insurance to include coverage for treatments by every category of licensed health care provider was not preempted by the Employee Retirement Income Security Act (ERISA), where that state law only applies to insurance policies issued to insureds by disability insurers, health care service contractors and health maintenance organizations, and no other entities, and does not apply to welfare benefit plans or to administrative services contracts between those insurers and welfare benefit plans?

Whether the court of appeals correctly interpreted that Washington state statute to apply only to policies of insurance issued to their insureds by disability insurers, health care service contractors and health maintenance organizations, and no other entities?

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CHRISTINE GREGOIRE, in her official capacity as Attorney General for the State of Washington; DEBORAH SENN, in her official capacity as Insurance Commissioner of the State of Washington,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR RESPONDENTS IN OPPOSITION

STATEMENT OF THE CASE

Respondents file this brief in opposition to the petition of Washington Physicians Service Association and other Health Care Service Contractors (HCSCs) and Health Maintenance Organizations (HMOs) for a writ of certiorari to

review the judgment of the United States Court of Appeals for the Ninth Circuit. That court directed entry of summary judgment that Washington's Every Category of provider statute was not preempted by the Employee Retirement Income Security Act (ERISA).[1] 29 U.S.C. § 1001 et seq.

I. NATURE OF THE CASE

The Every Category Act requires that "every health plan delivered, issued for delivery or renewed by a health carrier . . . permit every category of health care provider to provide health services. . ." for conditions listed in Washington's Basic Health Plan.[2] Wash. Rev. Code § 48.43.045 (1998). The phrase "delivered, issued for delivery or renewed" is a term of art which refers to the sale of insurance products to policyholders. A "carrier" or "health carrier" is a disability insurer, a health care service contractor or a health maintenance organization regulated by the State of Washington. App. at 107; Wash. Rev. Code § 48.43.005(17) (1998). A "health plan" is any "policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services. . . ." App. at 107; Wash. Rev. Code § 48.43.005(18)(1998). The phrase "policy, contract, or agreement" lists the terms used in Washington's disability insurance law, health care service contractor law, and health maintenance organization law, respectively, to refer to the insurance products issued to their

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[1] The decision of the court of appeals is reported at 147 F.3d. 1039 (9th Cir. 1998) and the decision of the district court is reported at 967 F. Supp. 424 (W.D. Wash. 1997).

[2] The Act also requires that the services be within the providers' permitted scope of practice and comply with the carriers' administrative procedures and standards for utilization review, cost containment, cost-effectiveness and clinical efficacy. App. at 111-12; Wash. Rev. Code § 48.43.045 (1998).

insureds.[3] (For brevity, "policy" will be used jointly for "policy, contract, or agreement" and "policyholder" or "insured" for the policyholder, contract holder or HMO participant having coverage under a "policy, contract or agreement.") The Act, therefore, requires that every policy issued by a disability insurer, HCSC or HMO to its insureds provide coverage for treatment by every category of health care provider licensed in Washington. App. at 7; 147 F.3d at 1042.

The Act does not apply to employee benefit plans established pursuant to ERISA (ERISA plans). App. at 9-12; 147 F.3d at 1043-44. They are not HMOs, HCSCs or insurers regulated by the State of Washington and do not come within the definition of "carrier." ERISA benefit plans that do not purchase insurance can offer any benefits they choose, unaffected by the Act. App. at 9-10, 12; 147 F.3d at 1044. The Act does not apply to Taft-Hartley benefit plans, multiple employer benefit plans, church benefit plans, or other welfare benefit plans. App. at 10; 147 F.3d at 1044. Such plans are also not HMOs, HCSCs or disability insurers regulated by the State of Washington and also do not come within the definition of "carrier." Finally, the Act does not apply to health carriers when they act under a contract to provide third party administrative services or as plan administrators. App. at 10-11; 147 F.3d at 1044. When providing administrative services, the carrier does not issue a policy of insurance to any policyholder, and there is no

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[3] Under Washington law, disability insurers issue "policies" to their insureds, Wash. Rev. Code § 48.21.050 (1998), HCSCs issue "contract[s]," Wash. Rev. Code § 48.44.010(11) (1998), and HMOs issue "agreements . . . to participants," Wash. Rev. Code § 48.46.060(2) (1998). *See* Wash. Rev. Code § 48.21.200(1) (1998), prohibiting any "disability insurance policy, health care service contract, or health maintenance agreement" from reducing benefits because of the existence of certain other insurance benefits.

"health plan" (policy, contract or agreement of insurance) to which the Act can apply.

The Act is not a so-called "any willing provider" statute. App. at 18-19; 147 F.3d at 1047. An any willing provider statute requires a health carrier to allow an insured to see any individual provider (in an otherwise covered category of providers) willing to abide by the terms of the insurance plan. *Id.* The Act does not give any insured a right to treatment by any individual provider, and does not require that any carrier contract with or reimburse treatments by any individual provider. Health carriers may continue to utilize closed panels of providers, to select the individual providers with whom they will contract or whom they will reimburse, and to require the use of gatekeeper physicians. Unlike "any willing provider" laws, which do not expand the categories of providers whose services are covered, and therefore do not affect the types of treatments covered by the insurance policy, the Act expands the types of medical services and treatments available to insureds by expanding the categories of providers whose treatments are covered. App. at 18-19; 147 F.3d at 1047.

Prior to passage of the Act, Washington law required policies issued by disability insurers, HCSCs or HMOs to include coverage for services by some but not all categories of providers licensed in Washington.[4] Different requirements applied to disability insurers, HCSCs and HMOs. The effect of the Act was to expand and make uniform the categories of

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[4] For example, Wash. Rev. Code § 48.44.310 (1998), required coverage for services by chiropractors and Wash. Rev. Code § 48.44.570 (1998) required coverage for denturists. Other categories mandated for some or all types of carriers included chiropody, optometry, psychology, and certain registered and advanced registered nurses. Since the Act mandates coverage for all categories of licensed provider, it also mandates coverage for services by Doctors of Medicine and Doctors of Osteopathy.

providers required to be covered by HCSCs, HMOs and disability insurers.

II. THE PROCEEDINGS BELOW

This is a challenge to the Act as written, not as applied.[5] The district court interpreted the Act as applying directly to "certain ERISA plans" and to church and government plans "administered by a health carrier . . . which are . . . outside the insurance industry." App. at 50; 967 F. Supp. at 428. It held that HMOs, to which the Act expressly applies, "are not insurers. . . ." *Id.*[6] It concluded that since the Act did not require coverage of any additional medical conditions, it did not spread risk. App. at 52-53; 967 F. Supp. at 429. Based on its interpretation of the Act, the district court concluded that the Act "related to" ERISA plans, and did not satisfy the common sense understanding of the business of insurance, or any of the McCarran-Ferguson Act criteria for the business of insurance.

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[5] After both parties had filed their principal district court briefs on summary judgment, Plaintiffs filed affidavits that included certain attachments. Defendants responded with counter affidavits. Both sides moved to strike certain of the other's affidavits. The district court treated these motions as moot, since it did not consider the affidavits and attachments. App. at 58; 967 F. Supp. at 431. One attachment was the "Declaratory Order" referred to in the Petition. App. 86-87. All of Plaintiffs' references to the Order are to its nonbinding discussion and not the Order itself. The Order is the subject of a separate state court challenge. *Blue Cross of Washington & Alaska v. Senn,* No. 96-2-03203-1 (Thurston Cy. Sup. Ct.) That state proceeding was stayed by mutual agreement after the district court's decision. On October 28, 1998, Matter No. R 98-20, the Commissioner commenced a rulemaking proceeding with regard to the Act. The notice (CR 101) filed pursuant to Wash. Rev. Code § 34.05.310 (1998) stated that the "new rules will supersede [the] earlier Declaratory order."

[6] Neither Plaintiffs' briefs nor argument before the court of appeals attempted to defend the district court's conclusion that HMOs are not engaged in insurance.

The court of appeals rejected the district court's interpretation of the Act. It interpreted the Act as applying only to policies of insurance issued to insureds by HMOs, HCSCs and disability insurers, an interpretation that excludes church, Taft-Hartley, or other benefit plans, third party administrative arrangements, and ERISA benefit plans. It concluded that HMOs are engaged in the business of insurance. It interpreted the Act as requiring insurance policies to cover additional types of treatments and services, shifting to insurers and spreading among all insureds the risk that policyholders may need those treatments. Applying its interpretation of the Act, it found that the Act did not relate to ERISA benefit plans, and was within ERISA's insurance savings clause since it satisfied the common sense understanding of insurance and all three McCarran-Ferguson Act criteria for the business of insurance.

REASONS FOR DENYING THE WRIT

None of the considerations governing review on certiorari, as set forth in this Court's rules, support granting the requested writ. The court of appeal's opinion is wholly consistent with this Court's decision in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985), settled law as to the common sense understanding of insurance and the McCarran-Ferguson Act definition of the business of insurance, and this Court's recent decisions as to which state laws "relate to" ERISA benefit plans. It is not in conflict with the decisions of any other court of appeals; Plaintiffs' asserted conflicts are based on interpretations of the Act that the circuit court rejected. No issue of general or national importance is presented by the petition.

I. THE ACT IS A REGULATION OF THE SUBSTANTIVE TERMS OF INSURANCE POLICIES THAT THE COURT OF APPEALS CORRECTLY FOUND EXEMPT FROM PREEMPTION UNDER *METROPOLITAN LIFE INSURANCE COMPANY v. MASSACHUSETTS* AND SUBSEQUENT DECISIONS OF THIS COURT

In *Metropolitan Life*, this Court held that a Massachusetts statute requiring all policies of health insurance to provide mental health coverage, including coverage for services by specified categories of providers, was not preempted by ERISA.[7] In order to hold a state statute preempted by ERISA, a court must find that it "relates to" ERISA plans and does not fall within ERISA's insurance savings clause as a law that regulates insurance. In applying the savings clause, relevant considerations are the common sense understanding of insurance and the McCarran-Ferguson Act definition of the business of insurance. *Id.*

A. The Court of Appeals Correctly Applied the Insurance Savings Clause

Metropolitan Life reviewed ERISA's legislative history and concluded that Congress had not intended to invalidate existing state laws regulating insurance. 471 U.S. at 741-47. It looked to the types of state regulation of insurance policies common at the time of ERISA's adoption

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[7] The statute required coverage for outpatient services by psychotherapists, psychologists and certain mental health clinics, and inpatient care in licensed mental hospitals. *Attorney General v. The Travelers Ins. Co.*, 385 Mass. 598, 599 n.2, 433 N.E.2d 1223, 1224 n.2 (Mass. 1982). Unlike the Act, the Massachusetts statute expressly applied to ERISA benefit plans. The supreme judicial court severed its preempted application to ERISA plans from its application to insurers and upheld it as so severed. This Court affirmed.

as evidence of the types of state regulation that Congress had intended to preserve. It found that laws requiring policies to cover specified illnesses or conditions and laws requiring policies to cover services by particular categories of providers were commonplace, and were so well before Congress adopted ERISA. 471 U.S. at 729. By the time *Metropolitan Life* was decided, a substantial majority of states had adopted both types of statutes. 471 U.S. at 729.[8] The Massachusetts statute required that policies both provide coverage for mental illness and coverage for "services . . . rendered by a phychotherapist or by a psychologist licensed. . ." in Massachusetts and certain mental hospitals and mental health clinics. *Attorney General v. The Travelers Ins. Co.*, 385 Mass. 598, 599 n.2, 433 N.E.2d 1223, 1224 n.2 (Mass. 1982) (quoting statute).

Metropolitan Life then concluded that laws that regulate "the substantive terms of insurance contracts fall[] . . . squarely within the saving clause. . . . " *Metropolitan Life*, 471 U.S. at 742-43. "States have full power to prescribe the forms of contract and the terms of protection of the insured." 471 U.S. at 742 n.19 (internal citation and quotation marks omitted.) Among the laws that *Metropolitan Life* singled out as regulating the substantive terms of insurance policies are laws that mandate that policies provide coverage for certain conditions and laws that require that policies provide

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[8] In footnote 9, this Court noted that "a majority of states require that coverage for services . . . by an optometrist be either mandated or . . . offered. . . ." 471 U.S. at 792 n.9, citing Appendices IIB and III of the Brief of Amicus Curiae Health Insurance Association of America. Those appendices indicate that 37 states mandated coverage for optometrists, 30 for chiropractors, 30 for podiatrists, and 28 for psychologists. Other categories of providers mandated by states included nurse midwifes, chiropodists, physical therapists, audiologists, speech pathologists, opticians and certain counselors. By 1985, approximately forty-six states had passed laws mandating coverage for treatments by specified categories of providers. *Blue Cross & Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1337 n.9 (10th Cir. 1986).

"coverage for services rendered by a particular type of health-care provider." 471 U.S. at 729. The Every Category Act, of course, is simply another state law requiring coverage for services rendered by particular types of providers that *Metropolitan Life* holds are not subject to preemption. The Act merely expanded and made uniform the types of providers mandated for policies of insurance issued by disability insurers, HCSCs and HMOs.

Since the Act, as interpreted by the court of appeals, regulates the substantive terms of insurance policies, it falls within the common sense understanding of insurance and the McCarran-Ferguson Act. Certainly the common sense understanding of insurance includes within it the policy of insurance issued by a carrier to its insureds. Metropo*litan Life*, 471 U.S. at 740. This Court has long regarded "state regulation that centers around the contract of insurance. . ., the type of policy which could be issued. . ." as the core of the business of insurance. *SEC v. National Securities, Inc.* 393 U.S. 453, 460 (1969). Since the Act regulates the terms of the policy, it satisfies the common sense understanding of insurance.

As *National Securities* recognizes, practices and laws that affect the policy of insurance are also part of the business of insurance under the McCarran-Ferguson Act. 393 U.S. at 459-60. See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 239 (1979) (Brennan, J., dissenting) ("I start with common ground. Neither the Court . . . nor the parties challenge the fact that the . . . policy offered by Blue Shield to its policyholders . . . is the 'business of insurance.' [T]he policy both transfers and distributes risk.") *Metropolitan Life* applied this long-standing rule to cases involving ERISA preemption.

Since the Act affects the terms of the policy issued to the policyholder, it satisfies all three of the McCarran-Ferguson Act's criteria for the "business of insurance." The Act both transfers and distributes risk since it governs the

coverage the policy provides an insured. Just as the Massachusetts statute shifted the risk that insureds would need treatment by psychotherapists or psychologists, the Act shifts the risk that insureds will need treatment by the categories it mandates. Without the Act, policyholders whose gatekeeper physician concludes that they require treatment by a chiropractor or acupuncturist, for example, may not have coverage for such treatment.[9] The Act transfers to the insurer the risk that a policyholder will need such treatments, and the obligation to pay for them, and spreads that risk among all insureds. App. at 18-19; 147 F.3d at 1047. ("The Act works a substantive alteration of the insurance policy and mandates that the insurer cover an expanded list of treatments. It therefore spreads the risk . . ." among all insureds.) The Act is integral to the insurer-policyholder relationship since it affects the terms of the policy issued the insured; nothing is more integral to that relationship than the policy that prescribes the insured's rights and benefits, and the treatments and services for which the insurer will pay. It is limited to entities engaged in the business of insurance, since it only applies to policies issued by "health carriers," a term that is statutorily defined as HCSCs, HMOs and disability insurers regulated by Washington, and no other entities. The court of appeals' holding that the Act was not preempted by ERISA broke no new ground, and was squarely within the insurance savings clause as interpreted by *Metropolitan Life*.

B. The Court of Appeals Correctly Applied the "Related To" Requirement

The Massachusetts statute challenged in *Metropolitan Life* expressly applied to "any employees' . . . welfare fund,"

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[9] The Act expressly permits carriers to refuse coverage for treatments that are not efficacious or cost effective. Wash. Rev. Code § 48.43.045 (1998).

providing an express reference to ERISA plans. *New York State Conference of Blue Cross Plans v. Travelers Ins. Co.*, 514 U.S. 645, 663 (1995). Massachusetts "did not even try to defend its law as unrelated to employee benefit plans . . ." so it was unnecessary for *Metropolitan Life* to consider this issue "with any precision." *Travelers, 514 U.S. at 663.* Consequently, it fell to *Metropolitan Life's* progeny to define and explain ERISA's "relates to" requirement.

Those cases indicate that a decision by ERISA benefit plans to operate facilities or buy products otherwise regulated by a state does not cause laws regulating those products or facilities to "relate to" ERISA for purposes of preemption. In *DeBuono v. NYSA-ILA Medical and Clinical Services,* 520 U.S. 806 (1997), this Court held that a law affecting hospitals (by imposing a levy on them) did not relate to ERISA plans even though certain ERISA plans operated hospitals and had to comply with the challenged statute. The lower courts found that the law directly affected the operations and functions of those ERISA plans, and could cause those plans to limit their benefits. 520 U.S. at ____, 117 S. Ct. at 1750. This Court reversed, noting that the statute regulated hospitals, not ERISA plans, and that most hospitals were not operated by ERISA plans. The law was generally applicable to hospitals, and the fact that an ERISA plan chose to operate a facility in that industry did not cause laws of general applicability to that industry to "relate to" ERISA plans.[10] See *California Div. of Labor Standards v. Dillingham Constr. Co.*, 519 U. S. 316 (1997) (ERISA plan's operation

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[10] This Court also emphasized that any party asserting ERISA preemption "in a field . . . traditionally occupied by the states" bears the "considerable burden of overcoming the starting presumption that Congress does not intend to supplant state law." 520 U.S. at ____, 117 S. Ct. at 1751-52 (internal quotation marks and citations omitted.) Health and insurance, the two fields implicated by the Act, are both areas of traditional and long-standing state concern and regulation. *American Drug Stores Inc. v. Harvard Pilgrim Health Plan*, 973 F. Supp. 60, 65-66 (D. Mass. 1997).

of apprenticeship program did not cause state regulation of such programs to relate to ERISA plans); *Travelers*, 514 U.S. at 660-61 (state law applicable to all health policies except those issued by Blue Cross plans did not relate to ERISA plans, notwithstanding purchase of such policies by ERISA plans).[11]

The district court interpreted the Every Category Act as directly applying to employee welfare benefit plans subject to ERISA. The court of appeals rejected this interpretation, holding, instead, that the Act was a law generally applicable to health insurance that did not affect plans governed by ERISA unless they chose to purchase that separately regulated product. The Act "does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy." App. at 12; 147 F.3d at 1044-45. The court of appeals' conclusion that the Act, as so interpreted, does not "relate to" employee benefit plans governed by ERISA broke no new ground, but only applied this Court's decisions in *DeBuono*, *Dillingham*, and *Travelers*.[12]

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[11] The statute imposed a surcharge on such policies. *Travelers*, 514 U.S. at 650.

[12] Contrary to the Petition, this interpretation does not render the insurance savings clause obsolete. For example, a state law that directly applied to and regulated not the contents of the insurance product bought by an employee benefit plan (as does the Act) but the interaction between the buyer of the product and the seller might well "relate to" the purchasing employer or plan, since it would directly apply to them, but be exempted from preemption by the savings clause. Possible examples would be laws designating an employer or benefit plan as an agent of an insurer issuing group insurance policies to its employees for purposes of communications by employees to the insurer, or laws requiring a purchasing employer or plan to provide certain information to the insurer, on applications or otherwise. Respondents, of course, take no position on any litigation involving any such law.

The Petition argues that the Act "relates to" employee benefit plans because the Act "applies to every health plan issued by a Health Carrier [and] [u]nder Sections 3(1), 29 U.S.C. § 1002(3) of [ERISA], all health plans are employee benefit plans." Petition, 4-5. Having defined "health plan" as equivalent to an ERISA plan, the Petition repeatedly contends that the Act relates to ERISA because it "interferes with administration and structure of health plans." Petition at 8. This argument miscites ERISA and ignores the statutory definition of "health plan" in the Act. Contrary to the Petition, nothing in 29 U.S.C. § 1002(3) uses the term "health plan" as defined in the Act; it defines the term "employee benefit plan" as being an "employee welfare benefit plan." App. at 130. An "employee welfare benefit plan" is itself defined as a "plan, fund, or program . . . established or maintained by an employer . . ." for the purpose of arranging health care for its employees. App. at 130; 29 U.S.C § 1002(1) (emphasis added). By contrast, the Act defines the term "health plan" as a policy of insurance issued by an HCSC, HMO or disability insurer, something very different from an employee welfare benefit plan established by an employer under ERISA. App. at 9; 147 F.3d at 1042-43. [13] As interpreted by the court of appeals, "health plans" under the Act are insurance policies, not ERISA plans, and the Act's reference to "health plans" simply does not cause it to apply or relate to ERISA welfare benefit plans.

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[13] The Petition appears to use the phrase "health plan" to mean two very different things: the policy issued by an insurer (its meaning in the Act) and a welfare benefit plan established an employer under ERISA. Using the same term for two very different things does not make them the same.

II. THE DECISION BELOW DOES NOT CONFLICT WITH DECISIONS OF ANY OTHER COURT OF APPEALS

The Petition asserts conflicts with several other courts of appeals. However, for any conflict to arise, this Court would first have to reject the court of appeals' interpretation of the Act, and accept Petitioners'. Petitioners' real argument is not with the law applied by the court of appeals, but its interpretation of the Act. The alleged conflicts involve differences in result arising out of the specific language of the state statute before the court, not a difference in interpretation of ERISA or this Court's precedents.

The circuit court's holding that the Act does not "relate to" employee welfare benefit plans does not conflict with that of any other court of appeals. Both *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986), and *Stuart Circle Hospital Corp. v Aetna*, 995 F.2d 500 (4th Cir. 1993), *cert. denied*, 510 U.S. 1003 (1993), were decided before *Travelers*, *DeBuono* and *Dillingham*, and do not conflict with the circuit court's interpretation of those cases. Since they upheld the challenged statutes under the insurance savings clause, they did not need to analyze the "related to" issue at length; indeed, *Bell* does not discuss the "related to" issue at all. *Prudential Insurance Company of America v. National Park Medical Center, Inc.*, 154 F.3d. 812 (8th Cir. 1998), and *CIGNA Healthplan of La. Inc. v. Louisiana*, 82 F.3d 642 (5th Cir. 1996), were decided after *Travelers* and did find state statutes preempted by ERISA.[14] However, both involved statutes that specifically applied to, and therefore directly related to, ERISA plans. *CIGNA Healthplan*, 82 F.3d at 649-50 ("Given that these enumerated entities constitute ERISA-qualified plans, the Any Willing Provider statute expressly refers to ERISA plans"); *National*

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[14] Both were "any willing provider" statutes; the Act is not.

Park Med. Ctr., 154 F.3d. at 824-25 ("[T]he Arkansas PPA has several provisions that make implicit reference to ERISA . . . through regulation of 'health benefit plans' that are necessarily subject to ERISA regulation.") The court of appeals distinguished these and similar cases from the Act: "In general, the state laws in these other cases all included ERISA plans in the definition of 'health plan' or otherwise expressly referred to ERISA plans. . . . [T]he Act is different . . . ." App. at 11; 147 F.3d at 1044. The Eighth Circuit distinguished the Arkansas statute before it from the Washington Act and the case at bar on the same basis:

> "[U]nlike the Arkansas statute, which is not so restricted, as explained above, the Washington statute made clear that the term 'health plans' referred only to plans offered by a 'health carrier,' not a benefit plan offered by an employer, and defined 'health carrier' to include only a disability insurer, a health care service contractor, or an HMO. . . . Indeed, the Ninth Circuit . . . recognized that the narrow language of the Washington act distinguished the case from the numerous cases that have found a reference to ERISA plans in a state's regulation of health plans, in which the state laws . . . all included ERISA plans in the definition of 'health plan' or otherwise expressly referred to ERISA plans. . . . Again, this court holds that the Arkansas PPA does have both express and implicit references to ERISA plans." *National Park Med. Ctr.*, 154 F.3d at 825 (internal quotation marks omitted).

As both the Eighth Circuit and the court below recognized, their different results arose not from differing interpretations of ERISA or this Court's precedents, but differences in the state statutes before them.

Nor is this case part of an asserted conflict between the courts of appeals concerning the preemption of any

willing provider laws. The Washington Every Category Act is not an any willing provider statute.[15] App. at 18; 147 F.3d at 1047. An any willing provider law "requires a health carrier to allow an insured to see any doctor willing to abide by the terms of the insurance plan and . . . provide . . . those treatments specified in the plan. Such a statute does not expand the conditions covered by the policy, *nor* does it expand the types of treatments available under the policy." *Id.* (emphasis in original). Thus, an issue in those cases is whether a statute that merely expands the choice of individual providers providing identical treatments within existing categories (Doctor A versus Doctor B, or Chiropractor A versus Chiropractor B), but not the types of treatments and services available, assumes and spreads risk under the McCarran-Ferguson Act or merely regulates the carrier-provider relationship. App. at 18; 147 F.3d at 1047; *Texas Pharmacy Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035, 1041-42 (5th Cir. 1997) (following *Stuart Circle Hosp. Corp.*, 995 F.2d at 503-04, in finding the choice of an individual provider to shift risk). Since the Act does expand the types of treatments available to insureds, any dispute among "any willing provider" cases as to whether a choice between individual providers within the same category spreads risk is simply not part of this case.

Moreover, the cases holding any willing provider statutes preempted involved statutes that applied to non-insurance entities such as ERISA benefit plans, and therefore were not limited to entities within the insurance industry under the McCarran-Ferguson Act. *National Park Med. Ctr.*, 154 F.3d at 830 (Arkansas PPA not limited to insurers); *Texas Pharmacy Ass'n*, 105 F.3d at 1038-39 (Texas statute not limited to insurers but "applies to ERISA benefit plans

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[15] An any willing provider law was before the people of the State of Washington as Initiative 673 at the November 1997, general election. It was not adopted.

themselves"); *CIGNA Healthplan*, 82 F.3d at 650 (statute not limited to insurers but applies to "self funded organizations, Taft-Hartley trusts, or employers who establish or participate in self funded trusts or programs"). Since the Act is specifically limited to HCSCs, HMOs and disability insurers, and does not reach entities outside the business of insurance, there is no conflict with those cases. *National Park Medical Center* also distinguished the Washington Act on this basis, and found no conflict with the court of appeals' decision in this case. 154 F.3d at 830.

Nor does this case conflict with any other court of appeals as to whether all three McCarran-Ferguson Act criteria must be satisfied for ERISA's insurance savings clause to apply. Although courts of appeals have split on this issue, compare *Cisneros v. UNUM Life Insurance Company*, 115 F.3d 669, 675 (9th Cir. 1997) (applying insurance savings clause where practice did not shift and spread risk), and *CIGNA Healthplan*, 82 F.2d at 650 (all McCarran-Ferguson Act criteria must be satisfied), this conflict is not presented by this case. In this case, the circuit court found that the Act "satisfies all three prongs of the McCarran-Ferguson test. . . ." App. at 20; 147 F.3d at 1047. As such, it would have been exempted from preemption under the Fifth Circuit's interpretation of the insurance saving clause, and there is no conflict between the decision in this case and that of any other court of appeals.

Impliedly recognizing that there is no conflict with any other court of appeals unless the Act is reinterpreted to create one (by, for example, applying it to administrative services arrangements or union plans, or turning it into an any willing provider law, despite its plain language), the Petition also addresses the heart of the dispute between the parties: the interpretation of the Act. Petition, 17-23. As they did in the district court, Petitioners contend that the Act reaches administrative services arrangements, Taft-Hartley benefit plans, and multiple employer benefit plans sponsored

by trade associations. However, the court of appeals' interpretation of the Act does not raise issues of general or national importance meriting review by this Court.

The Act requires "every health plan delivered, issued for delivery, or renewed by a health carrier. . ." to permit "every category of health care provider to provide health services. . . ." App. at 111; Wash. Rev. Code § 48.43.045 (1998). "Health plan" is statutorily defined as a "policy, contract, or agreement" to arrange, provide for or pay for health care services. App. at 107; Wash. Rev. Code § 48.43.005(18) (1998). "Policy, contact or agreement" is a term of art for the insurance products issued by disability insurers, HCSCs and HMOs, respectively, to their insureds; disability insurers issue policies, HCSCs issue contracts and HMOs issue agreements to their participants. *Compare* Wash. Rev. Code §§ 48.21.050, 48.44.010(11) and 48.46.060(2)(1998). Where the Washington Legislature desires to make a statute applicable to the insurance products issued by all three entities, it uses all three of these terms. See Wash. Rev. Code § 48.21.200(1) (1998) prohibiting any "disability insurance policy, health care service contract or health maintenance agreement" from containing provisions reducing benefits for certain other coverage. "Health carrier" is statutorily defined as a disability insurer, HCSC or HMO. App. at 111; Wash. Rev. Code § 48.43.005(17) (1998). Substituting these definitions in the text of the Act yields a requirement that every policy of insurance delivered, issued for delivery or renewed by a disability insurer, HCSC or HMOs provide coverage for services by all categories of licensed health care providers; the interpretation reached by the court of appeals. This issue of statutory construction is what this case is all about. Nothing in the court of appeals' interpretation of the Act violates standard rules or principles of construction, creates a conflict with any other court of appeals, or raises issues of general or national importance meriting review by this Court.

CONCLUSION

For these reasons, the Petition for a writ of certiorari should be denied.

Respectfully submitted,

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